EXHIBIT 6
DATE 2.23.07
SB 522

February 22, 2007

To whom it may concern:

We are writing in support of Senate bill 522 and prescription privileging for appropriately trained psychologists. We are aware that other states have enacted such legislation and there is now ample data demonstrating that appropriately trained psychologists can safely and effectively prescribe medications for the treatment of mental disorders. We work with psychologists on a daily basis and believe that prescribing psychologists would offer another much needed resource to our citizens in Montana.

Robert Byron, MD
1079 Community RD.
Hardin, MT 59034

David Mark, MD
310 N. Crow
Hardin, MT 59034

February 22, 2007

To whom it may concern:

I am writing in support of Senate bill 522 and prescription privileging for appropriately trained psychologists. Other states have enacted such legislation and there is now ample data demonstrating that appropriately trained psychologists can safely and effectively prescribe medications for the treatment of mental disorders. As a physician practicing in a rural area I can assure you that we are critically short of mental health resources and prescribing psychologists would offer another much needed resource.

G. Kirk Gastineau, DO
P.O. Box 9
Crow Agency, MT 59022
Phone: 406-638-3305

February 22, 2007

To Whom It Concerns:

I am writing in support of Senate Bill 522 and prescription privileging for appropriately trained psychologists. I believe that there is adequate data demonstrating that appropriately trained psychologists can safely and effectively prescribe medications for the treatment of mental health disorders.

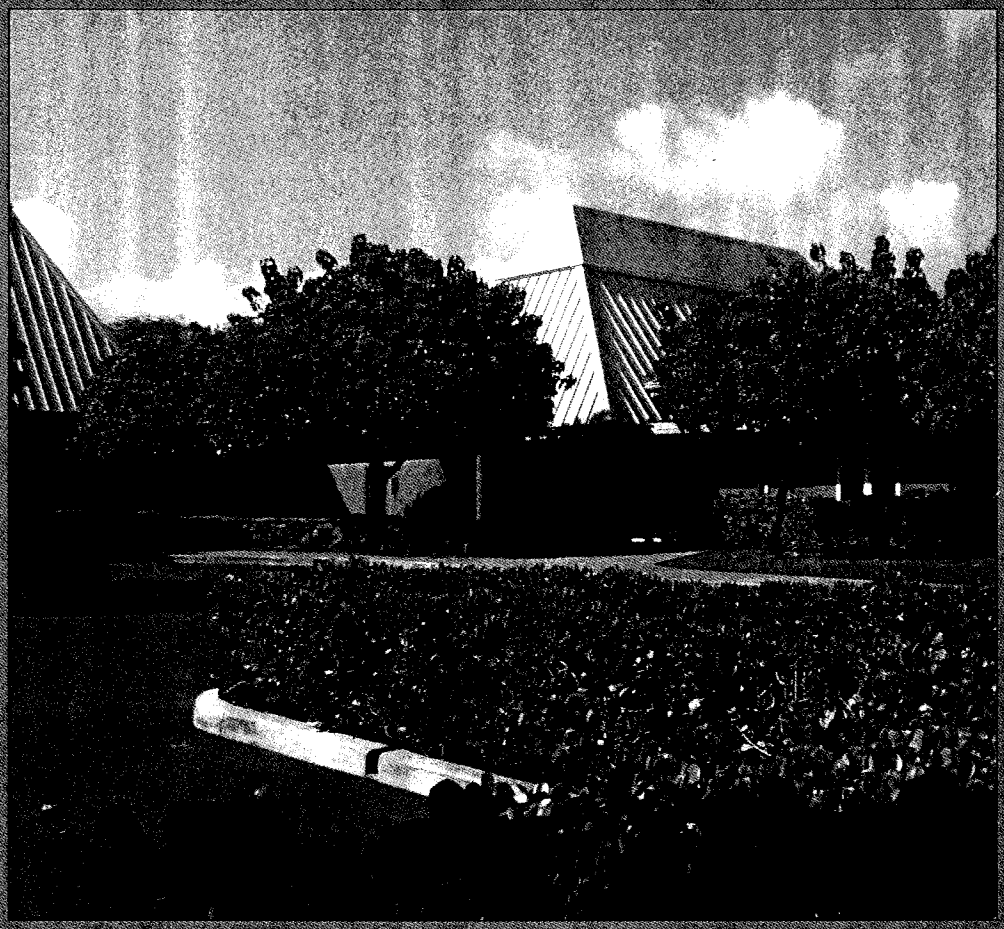
I have lived in rural Montana for 19 years and our shortage of mental health workers has only worsened in that time. As a past president of the Montana Chapter of the American Academy of Pediatrics, I have heard repeatedly the frustrations of pediatricians across the state; we all do much work with mental health issues, and are continually stymied by limited access to mental health services for our patients.

Please contact me by phone if there are additional questions or issues that you would like to discuss.

Sincerely,

Lori G Byron, MD, FAAP
Past-President, Montana Chapter, American Academy of Pediatrics
665-3038

Psychological Services



Editor

Patrick H. DeLeon, PhD

February 2007
Vol. 4, No. 1

ISSN 1541-1559
www.apa.org/journals/ser

Psychological Services
2007, Vol. 4, No. 1, 59–71

Copyright 2007 by the American Psychological Association
1541-1559/07/$12.00 DOI: 10.1037/1541-1559.4.1.59

Experiences From the Frontline: Prescribing in New Mexico

Elaine S. LeVine
The Center Through the Looking Glass

With legislation in New Mexico and Louisiana enabling psychologists to prescribe psychotropic medication for their patients, there is a new opportunity to demonstrate that psychologists can prescribe safely and address the needs of the underserved mentally ill. This article describes one psychologist's first 18 months' experience prescribing psychotropics from a biopsychosocial model of care. Case examples demonstrate that a psychologist with prescriptive authority can effectively assist patients and increase available services to those who have been waiting many months to receive care. The psychologist is in an excellent position to recognize ethnic and individual variation that impacts effective psychotropic intervention. The prescribing psychologist working within the biopsychosocial approach and collaborative primary care model becomes a valuable part of the primary health care team, allowing increased comprehensive patient care for medical and psychological conditions.

Keywords: prescriptive authority, biopsychosocial model of care, collaborative care, New Mexico Prescribing Psychologists' Act, medication management

Less than 10 years after the American Psychological Association (APA) Council officially endorsed prescriptive authority for psychologists and outlined recommended training (APA, 1996), psychologists are prescribing in New Mexico and Louisiana. In both 2005 and again in 2006 seven states and territories introduced prescriptive authority legislation and RxP Task Forces were active in many more states (Sullivan, 2005; Baker, 2006). Commenting on this dramatic maturing of the prescriptive authority agenda, DeLeon (2003, p. XIII) notes it is "fundamentally a social policy agenda insuring that all Americans have access to the highest possible quality of care. . .wherein psychotropics are prescribed in the context of an overarching psychologically based treatment paradigm." The agenda for psychologists prescribing is inspired by the premise that psychologists so trained will play central roles in primary health care delivery. Psychologists will then serve at the gateway to the health care system, diagnosing and treating psychological problems and referring patients to physicians as needed. At this gateway, prescribing psychologists can more readily access and effectively aid underserved populations such as rural populations isolated from services, elderly in nursing homes, and those suffering from severe mental illness. Thus, prescribing psychologists can provide more cost-effective, comprehensive mental health care by combining psychotherapy with medication management while working within an interdisciplinary model that increases access in rural and other underserved communities (Harowski, Turner, LeVine, Shank, & Leichter, 2006; Wiggins, 1992; Resnick, 1997; Sammons, Paige, & Levant, 2003).

Despite these many projected benefits of the prescriptive authority agenda, some individuals within the profession, as well as those external to it, remain actively opposed. They express concerns about whether psychologists can be trained to prescribe safely and that, once trained in psychopharmacology, psychologists will eschew their core training in psychological intervention (Hayes & Heiby, 1996). In contrast, the work of the prescribing psychologists trained through the Department of Defense (DoD) Psychopharmacology Demonstration Project offers solid evidence that psychologists can be trained to prescribe psychotropic medication safely and effectively while maintaining their identity and practice as psychologists (Newman, Phelps, Sammons, Dunivin, & Cullen, 2000). The competence of these DoD prescribing psychologists

Correspondence concerning this article should be addressed to Elaine S. LeVine, The Center Through the Looking Glass, 1395 Missouri Avenue, Las Cruces, NM 88001. E-mail: eslevine@hotmail.com

who have been prescribing successfully for 10 years substantiates DeLeon's thesis of the maturing of the RxP agenda.

Now there is a new fledgling breed of civilian prescribing psychologists in New Mexico and Louisiana. These psychologists must follow in the impressive footsteps of the DoD prescribing psychologists by becoming safe and effective prescribers while maintaining their identities as psychologists. As they increase in numbers, these new prescribing psychologists must also demonstrate that the goals and hopes of the proponents of the RxP agenda are correct: prescribing psychologists will promote more holistic care and will expand care to underserved populations. The success of the new prescribing psychologists can provide momentum to legislative efforts in other States and can counter the concerns of RxP opponents.

In 1996, the president of the New Mexico Psychological Association initiated a task force on prescriptive authority of which I was the original chair. In March of 2002, New Mexico became the first state to pass a law allowing properly trained psychologists to prescribe psychotropic medication for their patients. After a painstaking process of implementation, regulations were enacted in February of 2005.

Sections 61–9–2 through 61–9–19 of the New Mexico Prescribing Psychologist Act state that psychologists can apply for a conditional prescriptive certificate after completing the following:

1. Four hundred fifty hours of academic training in the field of psychopharmacology which include the coursework recommended by the APA Council of Representatives (1996, Recommended Postdoctoral Training in Psychopharmacology for Prescriptive Authority).

2. Eighty-hour practicum with a primary care provider.

3. Treatment of 100 patients with psychotropic medication for a minimum of 400 hours with pharmacotherapy such that a range of patients, conditions, and stages of the therapeutic process are part of the training.

4. Passage of the Psychopharmacology Examination for Psychologists developed and administered by the APA College of Professional Psychology (2000).

In order for the conditional prescribing psychologist to then apply for an independent prescriptive certificate, the psychologist must:

1. Treat 50 patients for a period of two years with psychotherapy, psychotropic medication management, and evaluation,

2. Be supervised by a physician for a minimum of four hours monthly,

3. Pass a random review of 10 charts by a panel, as specified in the Law, that is nominated by the Board of Psychologist Examiners.

Upon obtaining a prescriptive authority certificate, the psychologist can prescribe independently but must collaborate with the patient's primary care physician about planned interventions to assure patient safety and the psychologist must obtain at least 20 hours annually of continuing education in psychopharmacology.

In February of 2005, two psychologists in New Mexico (Elaine LeVine, PhD. and Mario Marquez, PhD) were awarded conditional prescribing certificates. By August 2006, five New Mexico psychologists had received conditional prescribing certificates. The following case studies of one of New Mexico's initial prescribing psychologists highlight how the addition of pharmacotherapy to the psychological regime plus the interdisciplinary care has led to significant patient improvements.

It is with recognition of the responsibility of the new prescribing psychologists to the RxP agenda that the following case summaries are offered regarding one New Mexico psychologist's first 18 months expanding her practice to include pharmacotherapy.

Method

Treatment Setting

All patients were seen in a private outpatient facility, The Center Through the Looking Glass, Las Cruces, New Mexico. This psychologist and other psychologists there serve patients of all ages, accepting by means of payment Med-

icaid, Medicare, managed care, private insurance, and self-pay.

Procedures

The psychopharmacology literature identifies various models for intervention in patient care, including but not limited to traditional psychotherapy with the adjunct of pharmacotherapy, consulting with primary care physicians about appropriate medication, and collaborating with other psychologists and mental health care workers to provide psychotropic intervention for their patients. This conditional prescribing psychologist decided, at least initially, to limit her psychopharmacological intervention to her patients she was also seeing for traditional therapy.

Patient Demographics

Table 1 summarizes the percentage of patient load seen each week for whom this psychologist is responsible for medication management as part of the biopsychosocial treatment approach. Upon first receiving a prescriptive authority certificate in February 2005, this psychologist prescribed medication for a very small percentage of patients. However, after 18 months of practice as a conditional prescribing psychologist, psychotropic intervention is included in approximately 40–50% of the patient load.

The brief time as a prescribing psychologist limits long-term predictions. However, it is interesting to note that this prescribing load is somewhat higher than that described by the DoD Prescribing Psychologists, who have assessed that about less than 30% of their patients are treated with psychotropics (Sexton quoted in McGrath, Wiggins, Levant, Brown, & Stock, 2004). The difference may be attributable to changes in the populations served. Patients and physicians seeking this psychologist's services have learned that she is providing both psychotherapy and medication management, and they are looking for that particular specialization. In other words, the nature of the population served seems to be evolving to those with more serious psychopathology, necessitating a range of intervention strategies, including medication.

Table 2 summarizes the demographic characteristics of the 57 patients for whom this psychologist has been managing psychotropic medication since receiving a conditional prescribing certificate.

Patient ages have ranged from 6 through 89. Forty-three (75%) are Anglo, 13 (23%) are Hispanic, and two (4%) are Native American. Forty-two of the 57 (84%) are female. Twelve of the 57 patients (21%) are 19 years old or younger (while approximately 25–30% of my total patients are ages 19 years old and younger). By far, the majority of the patients are suffering major depression, anxiety disorders,

Table 1
Patients Seeking Medication Management and Psychotherapy When Number of Patients Seen Each Week Varied From 19–40

Month	Year	% of patients receiving both	Year	% of patients receiving both
January	2005		2006	40.5
February	2005	6	2006	59.67
March	2005	10.25	2006	58.25
April	2005	9.5	2006	39.5
May	2005	25.75	2006	50
June	2005	29.5	2006	50
July	2005	40	2006	41.75
August	2005	47	2006	
September	2005	40	2006	
October	2005	38.75	2006	
November	2005	46.25	2006	
December	2005	46.75	2006	
	Average for 2005	31	Average for 2006	49

Table 2
Demographics by Percentage of Fifty-Seven Patients Seen For Combined Psychotherapy and Psychotropic Intervention February 2005—July 2006

Demographic data	Percentage
Age ranges	
0–10	4
10–19	18
20–29	11
30–39	16
40–49	14
50–59	19
60–69	12
70–79	2
80–89	5
Ethnicity by patient report	
Anglo	75
Black	0
Hispanic	23
Native American	4
DSM–IV Diagnoses	
Major depression	40
Substance dependence and abuse	18
Anxiety spectrum disorder	16
Personality disorder	12
Dysthymia	11
PTSD	11
ADHD	8
Adjustment disorder	5
Bipolar II	4
Bipolar I	2
Pervasive development disorder	2
School avoidance	2
Dementia	2
Hypochondriasis	2
Impulse control disorder	2
Bulimia	2
Obsessive compulsive disorder	2

Note. *DSM–IV* = *Diagnostic and Statistical Manual of Mental Disorders*–fourth edition; PTSD = posttraumatic stress disorder; ADHD = attention-deficit/hyperactivity disorder.

substance dependence/abuse, and posttraumatic stress disorder. These common diagnoses treated also include patients with Bipolar I and Bipolar II disorder, personality disorders, and several who suffer frank psychotic symptomology.

Table 3 presents details of cases discussed in this article. The right-hand column of Table 3 report initial outcome data as determined from patients' subjective reports and symptom checklists completed by the psychologist. Of the 57 patients treated with combined psychotropic and psychotherapeutic intervention, 65% showed remission of difficulties and were stabilized, while 35% were improved, but medication management and active psychotherapy were still needed. Four patients, 6%, declined initial or additional psychotropic intervention. Of those four patients, three achieved stabilization without medication.

Table 3 reveals that many of the patients are diagnosed with significant medical conditions. This finding seems striking. It is possible these data differ from the patient population that the conditional prescribing psychologist treated before having a conditional prescribing certificate because current referrals tend to be more psychologically and medically impaired. It is also possible that a prescribing psychologist keeps more complete records of patients' medical conditions so that psychologist is more knowledgeable about patient's medical concerns. In either case, these data illuminate the importance of prescribing psychologists' obtaining extensive training in pathophysiology and treatment of physical disorders and, as will be further explicated in the subsequent section, the value of the collaborative relationship with treating physicians.

Results

The primary benefits of psychologists' prescribing fall into four major categories, as listed in Table 4. First, prescribing psychologists can expand access to care by providing psychotropic care to patients who otherwise had none. For example, Patient 2 is a teenage boy with classic symptoms of Prader-Willi Syndrome, although chromosomal testing was inconclusive. His pediatrician and family waited three and a half months for an appointment with a child psychiatrist. During their first session with this child specialist, the psychiatrist talked with the young man and his mother for about 15 minutes. The psychiatrist said that he wanted to request records from the other treating doctors before prescribing medication, but related to the psychiatrist's patient overload, there was no follow-through. In collaboration with the patient's pediatrician, this psychologist began prescribing psychotropic intervention as well as offering psychotherapy for this young man. The addition of an atypical antipsychotic to the

Table 3
Description of Patients Seen for Medication Management as Well as Psychotherapy

Patient demographics						Treatment variables		Outcomes		
Pt Id[a]	Age range	Sex	Ethnicity	*DSM–IV* diagnosis	Medical conditions	Type of psychotherapy initiated & date initiated	Type of psychotropics & date initiated[b]	Stabilized	On-going	Decided against Rx
							Dextroamphetamine sulfate (OD & still refilled) Bupropion (OD) DC'd by Le Vine March 20, 2005			
2	10–19	M	A	299.80 Pervasive development disorder NOS	Prader-Willi broad spectrum disorder	December 19, 2003 interpersonal play & family therapy	Sertraline (OD & still refilled) Risperidone March 20, 2005 DC June 10, 2005 Aripiprazole August 9, 2005 Trileptal (with OD) June 5, 2006	X		
4	60–69	M	A	Bipolar II	Psoriasis	February 28, psychodynamic, in particular, interpretation of relationship	Valproic acid March 22, 2005 Zolpidem (with OD) March 22, 2005	X		
9	50–59	F	NA	Major depression	None	January 9, 2004 Supportive & uncovering psychotherapy	Fluoxetine July 20, 2005 Bupropion April 11, 2005 DC April 26, 2005 Trazodone April 11, 2005 DC April 26, 2005 Olanzapine (OD) DC May 17, 2005 Alprazolam (OD) DC February 1, 2006	X		
10	10–19	M	A	Substance induced psychotic reaction NOS	None	April 13, 2005 Thought stopping, cognitive restructuring	Aripiprazole February 2005 DC February 1, 2006 (by pt) Sertraline June 1, 2005 Amitriptyline (OD) DC October 2005			

(*table continues*)

Table 3 (*continued*)

Patient demographics						Treatment variables		Outcomes		
Pt Id[a]	Age range	Sex	Ethnicity	*DSM–IV* diagnosis	Medical conditions	Type of psychotherapy initiated & date initiated	Type of psychotropics & date initiated[b]	Stabilized	On-going	Decided against Rx
13	50–59	F	A	Major depression with melancholia	High blood pressure	March 22, 2005 Behavioral monitoring, supportive psychotherapy	Escitalopram oxalate April 22, 2005 Nortriptyline October 2005	X		
17	10–19	F	H	ADHD learning disability	Wolff Parkinson White	August 20, 2005 Guidance/ behavioral psychotherapy	Methylphenidate November 2, 2005 Citalopram (OD) DC June 28, 2005		X	
20	60–69	M	A	Major depression, dysthymia	Cardiovascular disease	June 2, 2005 Brief psychodynamic psychotherapy	Escitalopram oxalate July 14, 2005 Zolpidem (OD) Bupropion July 19, 2005	X		
21	30–39	F	H	Major depression, alcohol dependence, borderline personality disorder	None	December 9, 2004 Bibliotherapy, marital therapy, AA, behavioral therapy	Escitalopram oxalate December 21, 2005 DC February 25, 2006 Risperidone December 29, 2005 DC March 2006 Alprazolam (OD) DC July 2005 Paroxetine July 18, 2005	X		
23	50–59	M	A	Generalized anxiety disorder	Pulmonary embolism, blood clots in leg	July 11, 2005 Supportive, brief psychodynamic psychotherapy	DC July 20, 2005 Clonazepam September 21, 2005 Sertraline December 15, 2005 DC December 31, 2005 Lamotrigine (OD) Venlafaxine (OD) DC August 8, 2005	X		

Table 3 (*continued*)

Patient demographics						Treatment variables		Outcomes		
Pt Id[a]	Age range	Sex	Ethnicity	*DSM–IV* diagnosis	Medical conditions	Type of psychotherapy initiated & date initiated	Type of psychotropics & date initiated[b]	Stabilized	On-going	Decided against Rx
26	40–49	F	A	Borderline personality disorder, polysubstance abuse	Chronic back pain, high blood pressure (caused by Effexor)	August 8, 2005 Brief psychodynamic psychotherapy, marital therapy, family therapy, contracting, role-playing	Lamotrigine (OD) Venlafaxine (OD) DC August 8, 2005 Risperidone September 5, 2005 DC September 27, 2005 Valproic acid June 23, 2006 Ziprasidone August 15, 2005 DC September 1, 2005 Quetiapine (OD) DC October 10, 2005	X		
27	40–49	F	H	Major depression	None	August 9, 2005 Assertiveness training, supportive psychotherapy	Escitalopram oxalate September 26, 2005	X		
54	50–59	F	A	Major depression	Crohn's disease	May 9, 2006 Brief psychodynamic psychotherapy	Sertraline (OD) Paroxetine June 6, 2006		X	

Note. M = Male; F = Female; A = Anglo; H = Hispanic; *DSM–IV* = *Diagnostic and Statistical Manual of Mental Disorders*–fourth edition; ADHD = attention-deficit/hyperactivity disorder; Pt. Id = patient identification number; NOS = not otherwise specified; Rx = prescription; OD = other doctor prescribed; DC = discontinued medication; Pt. = patient.
[a] Description of medication management of the psychologist's other patients not specifically discussed in this article can be obtained from the author. [b] Medications prescribed by other physicians not followed by date initiated.

patient's previous treatment by a stimulant helped the patient think more clearly and addressed what could be labeled as the negative symptoms of his pervasive developmental disorder. In other words, the addition of the atypical antipsychotic facilitated his capacity to understand and relate to others. With this increased capacity to process affective stimuli, the patient was successfully treated in individual play therapy and family therapy. A focus of the individual therapy was to help the patient begin to process his relationships on a more sophisticated level, specifically, to learn how to interact in reciprocal relationships and to develop empathy for others. Play therapy that focused on the interpersonal dynamics between the therapist and young man was helpful in this regard. Family therapy was used to reinforce learning about appropriate social interchanges and also to develop some systematic expectations and reinforcers that all members of the family could agree to. Serious symptoms, such as his homicidal threats to others, severe cutting, and inability to get along with peers at school, have terminated, and he is evidencing reasonable adjustment to school and at home.

Second, the case studies indicate that the authority to prescribe as well as provide psychotherapy has improved care with several patients

Table 4
Patient Benefits of Psychologists' Obtaining Prescriptive Authority Substantiated by One Prescribing Psychologist's 57 Patients Treated Over 18 Months

Benefit	Substantiating cases
Prescribing psychologists can expand access to psychotropic care for patients who otherwise could obtain none	2, 21, 32
Prescribing psychologists can improve care for patients receiving insufficient care	1, 3, 6, 8, 10, 13, 23, 24, 26, 33 40, 42, 53, 54. 55, 61, 62
Prescribing psychologists can provide more holistic care from a biopsychosocial model of intervention	2, 4, 6, 7, 8, 9, 13, 16, 17, 20, 24, 26, 28, 38, 43, 45, 49, 56, 62
Prescribing psychologists can more effectively employ a best practice model comprised of extensive knowledge about the physiology of the patient and the biological mechanisms of medication and an ongoing therapeutic relationship and integrative records that guide holistic treatment. Aspects more effectively addressed include:	
Clearer differentiation of side effects of medication, disease state, and effects of psychosocial stressors	8, 9, 10, 13, 19, 20, 2, 6, 48, 49
Identification of polymorphic responses, across sexes and cultural groups as well as how cultures must be considered in evaluation psychotropics	9, 40, 41
Integration of psychopharmacology and psychotherapy that maximizes care	1 through 62
Understanding and interpreting "non compliance" as a transferred response to the medication and therapy	3, 4, 12, 14, 15, 18, 23, 32
Dealing with the psychological concomitants of health care issues	3, 7, 13, 20, 45, 54, 59
Reducing multiple medications by relying upon psychological interventions	8, 15, 36, 43, 49, 52

receiving insufficient care. Patient 10 is a young man who was treated for a serious psychotic break subsequent to his illicit drug use. The patient had been hospitalized and was maintained on olanzapine. However, the side effects of this medication were preventing him from taking a sufficient dose to totally manage his primary symptom of thought broadcasting. His ego-alien experience that others could hear his thoughts disturbed him greatly. His psychiatrist was in the Midwest, although he had moved to New Mexico, in hopes of attending the local university. He was treated by his psychiatrist every three months for a brief follow-up. From what could be determined in records, there had been no laboratory tests to assess for possible effects of the psychotropics for over two years. The olanzapine was discontinued, and the patient was prescribed aripiprazole, an atypical antipsychotic medication, that was significantly less sedating for him. Initially, the patient's subjective estimate was that he suffered from thought broadcasting about 50% of his waking hours. He estimated that the change to a less sedating and higher dosage of an atypical antipsychotic provided control over the thought broadcasting 90% to 100% of his waking hours each day. The remaining difficulty with the thought broadcasting was addressed through thought-stopping techniques as well as some cognitive restructuring. The cognitive restructuring was intended to modify the patient's exquisite sensitivity to others' evaluations of him. With the combination of behavioral thought-stopping techniques, cognitive restructuring to develop more self-acceptance, and psychotropic intervention, this patient was able to gain employment as well as to return to college.

Case studies also indicate that the authority to prescribe has also allowed for more holistic care for many patients. Because the patients spend more time with the psychologist than with the primary care physician, the psychologist often hears of medical symptoms of which the primary care physician is not aware. As a prescriber in a collaborative relationship with the primary care provider, this psychologist maintains frequent and thorough communication with the primary care physician, leading to more effective care of the patient's medical condition. For example, Patient 20 described a "leaded feeling" in his legs. Because the patient enumerated many vegetative symptoms associated with his depression, both he and the primary care physician assumed that the sensation in his legs was associated with the anergy of his

depression. However, as we worked through his depression, the physical symptoms in his legs did not abate. In working closely with the primary care physician, we identified this symptom as a side effect of the medication he was taking for his high cholesterol.

A related benefit of prescribing psychotropic medication is that it broadens the psychologist's knowledge about the patient as well as providing more information to the patients' primary care physician. Some have wondered how well the collaborative relationship would work. To date, this psychologist has formally collaborated with 12 primary care physicians (including a number who were known previously, while others are new professional contacts) regarding psychotropic medications for her patients. These primary care physicians have been cooperative, sharing results of laboratory tests and accepting this psychologist's recommendations for intervention. Several physicians have commented that they perceive a difference in how a psychologist approaches psychopharmacology than other prescribers. Specifically, prescribing psychologists are very interested in the more cautious, systematic way psychologists develop diagnoses. Others have expressed their appreciation that this psychologist seems to use a minimum of medication and relies upon less invasive means to assist patients when possible.

A fourth benefit revealed by these case analyses is that a prescribing psychologist can more effectively employ a best practice model. A best practice model in psychopharmacology can be viewed as comprised of three primary components: extensive knowledge about physiology of the patient and the biological mechanisms of medication, an ongoing therapeutic relationship, and careful means of maintaining records.

Although the importance of the psychologist understanding the patient's physiology as well as mechanisms of action of the drugs is self evident, several cases highlight that the more the psychologist understands about the biological basis of illness, the more helpful the psychologist can be. Case 13 returned to therapy after being stabilized on medication because of complicated bereavement, complaining that the antidepressant escitalopram oxalate was causing side effects. In discussing her symptoms, these side effects seem more likely caused by the amitriptyline that had been prescribed by her primary care physician for sleep and mild headaches. Exploration in therapy revealed that the patient had increased the amitriptyline because she was having constant headaches. She was also self-medicating with four to five analgesics four times a day. She had not informed her primary care physician that her headaches were so severe and that she was employing over-the-counter analgesics extensively. A rebound headache syndrome was diagnosed. Treatment of this condition necessitates terminating the use of over-the-counter analgesics. Interestingly, the plan and support for accomplishing the discontinuance of the analgesics were completed by the psychologist and patient as a part of the psychotherapy. The plan included careful monitoring of the amount of tricyclic antidepressant taken at night to help with headache management, charting of headaches to identify environmental and food triggers, and a gradual decrease of the over-the-counter analgesics. The patient was able to discontinue the frequent use of the over-the-counter analgesics, and her freedom from the extensive use of analgesics itself provided significant psychological gains. She felt much more in control, a greater sense of well-being, and an increased optimism about her future.

Reactions in Case 9 reveal the importance of the psychologist being extremely sensitive to how medications are metabolized by members of various ethnic groups. This Navajo patient was placed on a very small amount of bupropion. The typical side effect of bupropion is overstimulation of the nervous system. In this patient's case, a small amount of bupropion prompted an extreme, sedating side effect so that she began slurring her words and not remembering events that had occurred. Although the extant literature emphasizes the importance of recognizing that Native Americans may metabolize medications differently than those of the majority culture upon which most medication trials were completed, the exact nature of those differences is not well known. For example, it is not known if there are genetic mutations in different Native Americans tribes that could lead to varied liver enzyme processing so that specific Native American tribes might be slow or rapid metabolizers of certain drugs. Nor is it known if Native Americans tribes differ in protein binding of various drugs (Lin, Smith, & Ortiz, 2001). Some research on Native American metabolism of alcohol would seem to point

to the likelihood of some ethnic-specific aspects of the metabolism of the psychotropics (Smith, Mendoza, & Lin, 1999). Lin et al. (2001) predict that in the coming decade clinicians will be provided detailed maps showing the prevalence and distribution of genetic polymorphisms of drug-metabolizing enzymes as well as guidelines on what these polymorphisms mean for the use of particular drugs. Until such genetic fingerprinting is available, medication intervention must be monitored judiciously with patients from diverse ethnic backgrounds. Fortunately, the psychologists' frequent and close communication with patients, because they are conducting psychotherapy as well as medication management, facilitates close monitoring of these effects.

A best practice model for the prescribing psychologist also requires psychologists to view the effects of the medication in terms of the patient's psychosocial stressors. Lin, Anderson, and Poland (1995) write, "A large number of psychotropic agents are influenced substantially by ethnicity and culture. Recent advances in the realm of pharmacokinetics, pharmacogenetics, and pharmacodynamics have led to a greater understanding of some of the mechanisms responsible for such differences. In comparison, much less currently is known regarding how various psychosocial factors impinge on drug responses in different cultural settings" (p. 638). For example, in Southern New Mexico, a number of patients deal with issues associated with being raised in poor immigrant families from Mexico. Patient 27 was one of eight siblings raised by a mother who emigrated from Mexico and maintained her family by cleaning houses and by involvement with a series of men. This patient was neglected and had been subject to multiple sexual abuses in her childhood. She had learned that the safest way to survive was to "not be noticed." She presented with major depression and dysthymia, associated with the stress dating from her childhood as well as her current problems with an alcoholic mate and a teenage son experimenting with gang activity. Although she responded very positively to the antidepressant, it was clear that this patient needed to learn how to assert for her rights and needs, or stressors would reignite her depressive tendencies. Antidepressant intervention helped activate this withdrawn patient. Her energy increased, her thinking became brighter, and she felt more confident in enacting changes in her life. Supportive and reflective therapy facilitated the patient's confidence in her viewpoints and insights. Role-playing was used to practice new assertive approaches in dealing with family members.

Patient 17 suffers from a number of learning disabilities as well as attention deficit hyperactivity disorder (ADHD) that emerged very early in her development. Although stimulant medication has helped with the ADHD, her cognitive impairment led to poor choices in peer relationships. Although coming from a middle-class, Hispanic family, this teenager was pulled toward gang connections while clearly lacking the capacity to withstand their hardened ways. As her ability to focus increased with the aid of the medication, an important goal of psychotherapy was to help her think through friendship selections and behavior toward peers in a more constructive fashion. Because of her significant learning disabilities, the patient was initially engaged in very concrete analysis of how her behaviors and choices led to particular consequences. Fortunately, the use of a stimulant facilitated her being able to concentrate on this analysis. Gradually, her ability to assess social situations on her own has increased.

Patient 21 was raised in a relatively poor Hispanic family. Both her father and a brother had died from alcoholism. Therapy was prompted by her own substance abuse and marital problems. An interesting aspect of those problems was that her husband's family was from an upper-middle class Cuban background. An ongoing stressor in her life was a sense of being disparaged by her husband and his family for certain subcultural practices and because of her economic roots. Although she responded well to medication, behavioral management, and AA in controlling her drinking and raising her self-esteem, these intrafamily, ethnic issues needed to be addressed in order for treatment to be successful. The patient and her husband were referred for marital therapy, which included discussion of relating to their extended families. Thus, Cases 17, 21, and 27 demonstrate some of the specific stressors that must be considered when dealing with an ethnically diverse population.

An interesting aspect of why the best practice model of prescribing psychology involves integration of medication management with psy-

chotherapy is that the medication itself can be a transference object. For example, Patient 4 had many oppositional personality traits. Although some of these were acted out in how he responded to the therapist in general, the primary way the patient expressed his oppositionality to the therapist was by noncompliance with the recommended medication regime. Thus, when the psychologist recommended 500 mg valproic acid, this patient insisted that he only needed to take 125 mg; and when the psychologist later suggested to him that this was not a therapeutic dosage and perhaps he should consider discontinuing the medication if he was so uncomfortable about it, the patient increased his valproic acid to 500 mg. Upon recognizing the transference issues involved, the psychologist began using certain paradoxical techniques, and the patient responded quite positively. Eventually, the oppositional tendencies were discussed more directly, and the patient was helped to see that he related in this oppositional way to others. Patient 23 had experienced several disturbing interactions with physicians when in critical care for pulmonary embolisms. In his initial therapy with the psychologist, the patient seemed to transfer this fear of doctors with a fearfulness about any psychotropic that was prescribed. Interpreting his worries about the psychotropics in terms of his traumatic experiences in the hospital alleviated significant distress and created a much more effective therapeutic alliance regarding the discussion and use of the medication.

Interestingly, once a psychologist becomes involved in the patient's biological as well as psychological care, more psychological issues about health care arise. Patient 54 requested psychotherapy and medication management for agitated major depression characterized by disrupted sleep, sadness, constant worry, and difficulty concentrating. Years ago, the patient had been treated with paroxetine, which had helped with both of her psychological symptoms and, to some degree, her Crohn's disease. For a series of reasons, her primary care physician's and a previous psychiatrist had prescribed other antidepressants but would not try the paroxetine again, although the patient had expressed to her doctors that she felt it had been most effective for her. This psychologist prescribed a trial of paroxetine for the patient, and within a week, she reported feeling considerably better (suggesting that the psychologist, with his or her specialized training, may listen to a patient and base treatment on a more thorough understanding of the patient). This patient's agitation and anxiety were clearly exacerbated by family problems. Her husband had serious legal problems and had alienated the patient's parents, in-laws, and friends. Yet, the patient could see nothing he had done that was wrong. Her capacity for denial was extensive, and the lack of conscious understanding of relationship dynamics in her life was disrupting her sleep and preventing her from accurately assessing and managing her affairs. The denial was approached with some uncovering techniques and interpretations. This patient's defenses were so brittle that she could not face these unknowns without feeling enormous anxiety. Most interestingly, a breakthrough occurred in talking with her about her overall medical regime. The patient complained that her symptoms of the Crohn's disease had been worse recently. She was very afraid of having a new episode, as she had almost died during the last episode, during which it was necessary to resection a significant part of the intestines. Because the patient was accustomed to talking to me about medications, she shared that she had not been consistent in taking her medication for her Crohn's disease. She decided that her fear of exacerbation of the Crohn's led to a denial that she was sick and that the denial impeded her remembering to take the medication to maintain her health. After working through the denial of her illnesses, the patient was better able to see how the denial problem in her relationships was hindering her interpersonal effectiveness.

To make certain that a medication is effective, the prescribing psychologist seeks very systematic information about patients before intervening and very objective data about treatment effects. With this systematic information about patients, the prescribing psychologist may often terminate the use of medication in order to benefit a patient, putting into action the phrase used in RxP advocacy that "the right to prescribe is also the right and responsibility to not prescribe." Patient 26 had been placed on venlafaxine by a psychiatrist, but she did not go back to see him. She then received follow-up care from a pain specialist who noted she had high blood pressure and placed her on a blood pressure medication. Further, she was on a high

dosage of ziprasidone and quetiapine. In carefully tracking her history, the psychologist and patient determined that she did not have a blood pressure problem before starting the venlafaxine. Further, her symptomology at the time of treatment with this psychologist did not indicate a need for an antidepressant. When the venlafaxine was discontinued, her blood pressure dropped significantly, and she was subsequently able to discontinue the blood pressure medication. It was also determined that she was suffering extrapyramidal side effects from a relatively high dosage of atypical antipsychotics. When she was switched from ziprasidone to risperidone at a much lower equivalent dosage, many of her physical symptoms, including some of her upper back pain, remitted. She was then able to reduce reliance upon pain medications. When the patient began treatment with the psychologist, she was taking 11 medications; she now is taking six medications.

New systems of record keeping and integrating data from a biopsychosocial model of diagnosis and cases will need development and refinement. Some initial forms developed for the trainees and prescribing psychologists in New Mexico are available at the website for the Southwestern Institute for the Advancement of Psychotherapy at www.siaprxp.com.

Discussion

Initial experiences indicate that patients can benefit greatly from the application of a biopsychosocial model of care that a prescribing psychologist provides. The collaborative relationship with the primary care physician assures patient safety and that a breadth of knowledge is brought to bear from both the psychological and biological level. The authority to prescribe medication is a privilege and profound responsibility. It is a privilege because the medications can be of major assistance to patients, and it is a profound responsibility when a patient puts his or her physical as well as psychological well-being in the psychologist's hands. Combining psychotherapy with medication management requires the prescribing psychologist to develop a new system of when and how to talk about medication effects and side effects as well as when to focus upon psychotherapeutic issues. To maintain identity as a psychologist when prescribing, this system necessitates that the psychologist treat the patient as an equal partner in the entire process of psychotherapy and medication management. As prescribing psychology further evolves as a specialization, it will be important to systematize the information needed for evaluation and the best methods and processes for conducting a biopsychosocial approach to care.

Although the case studies briefly summarized in this article represent most rudimentary outcome data, these results highlight possible future studies that can offer empirical demonstration of the efficacy and effectiveness of a biopsychosocial intervention by prescribing psychologists. With a larger base, future studies can focus on a comparison between the psychologists' patients treated with psychotropic intervention to those not receiving psychotropic intervention. Such comparisons could point the way for future research about which patients choose to and profit most from medication, combined treatment, or psychotherapy alone. Other important research will collate outcome data to compare gains and negative effects when psychotropics are prescribed by prescribing psychologists in contrast to other prescribers.

When a psychologist combines his or her communication skills and understanding of behavior with advanced training in the biological basis of mental illness, the psychologist can be a meaningful part of the health care team. The psychologist's close relationship with the patient, combined with thorough communication with the medical provider, can offer more integrated and thorough care. As more prescribing psychologists interface with primary care physicians in these primary care settings, our patients, proponents, as well as those opposed to RxP efforts, will hopefully view prescribing psychologists as filling a new and valuable professional role and will embrace psychology maturing as a profession as it enters the arena of primary care prevention and treatment.

References

American Psychological Association College of Professional Psychology (2000). *Psychopharmacology examination for psychologists.* Washington, DC: Author.

American Psychological Association Council of Representatives (1996). *Recommended postdoctoral*

training in psychopharmacology for prescriptive privileges. Washington, DC: Author.

DeLeon, P. (2003). Forward: Reflections on prescribing authority and the evolution of psychology in the twenty-first century. In M. Sammons, R. Levant, & R. Paige (Eds.), *Prescriptive authority for psychologists: A history and guide*. Washington, DC: American Psychological Association.

Harowski, K., Turner, A., LeVine, E., Shank, J., & Leichter, J. (2006). From our community to yours: Rural best perspectives on psychology practice, training and advocacy. *Professional Psychology Theory and Practice, 37(2),* 158–165.

Hayes, S. C., & Helby, E. (1996). Psychology's drug problem: Do we need a fix or should we just say no? *American Psychologist, 51,* 198–206.

Lin, K., Anderson, D., & Poland, R. (1995). Ethnicity and psychopharmacology: Bridging the gap. *The Psychiatric Clinics of North America, 18,* 635–647.

Lin, K., Smith, M., & Ortiz, V. (2001). Culture and psychopharmacology. *The Psychiatric Clinics of North America, 24,* 523–538.

McGrath, R., Wiggins, J., M. Levant, R., Brown, A., & Stock, W. (2004). Professional issues in pharmacotherapy for psychologists. *Professional Psychology: Research and Practice, 35,* 158–163.

Newman, R., Phelps, R., Sammons, M. T., Dunivin, D. L., & Cullen, E. A. (2000). Evaluation of the psychopharmacology demonstration project: A retrospective analysis. *Professional Psychology: Research and Practice, 31,* 598–603.

Resnick, R. J. (1997). A brief history of practice-expanded. *American Psychologist, 52,* 463–468.

Sammons, M., Paige, R., & Levant, R. (2003). Prescribing psychologists: The future. In M. Sammons, R. Levant, & R. Paige (Eds.), *Prescriptive authority for psychologists: A history and guide* (pp. 192–212). Washington, DC: American Psychological Association.

Smith, M., Mendoza, R., & Lin, K. (1999). Gender and ethnic differences in the pharmacogenetics of psychotropics. In J. Herrera, W. Lawson, & J. Samek (Eds.), *Cross-cultural psychiatry* (pp. 323–341). New York: Wiley.

Wiggins, J. G. (1992). The case for prescriptive privileges for psychologists. *Psychotherapy in Private Practice, 11,* 8.

Received December 21, 2005
Revision received September 28, 2006
Accepted October 12, 2006 ■

E-Mail Notification of Your Latest Issue Online!

Would you like to know when the next issue of your favorite APA journal will be available online? This service is now available to you. Sign up at http://watson.apa.org/notify/ and you will be notified by e-mail when issues of interest to you become available!

Time

Most of the modules are taught on weekends approximately every five weeks. Some modules are home study courses.

Fees

$375.00 for each of 25 modules

In addition, students will purchase textbooks and medical supplies

To begin, simply download an application from the website and mail it with a copy of the license to practice as a mental health service provider to:

Elaine LeVine, Ph.D.
Training Director
Southwestern Institute for the Advancement of Psychotherapy
1395 Missouri Avenue
Las Cruces, NM 88001
PH: (505) 522-5466
FAX: (505) 521-8611

www.siaprxp.com

Or call Elaine LeVine for further information

Post-Doctoral Professional Development Coursework in Psychopharmacology for Psychologists

The coursework is organized by the Southwestern Institute for the Advancement of Psychotherapy (SIAP) in conjunction with the Counseling Psychology Program of New Mexico State University

SIAP is approved by the American Psychological Association to sponsor continuing education for psychologists SIAP maintains responsibility for the program

Now accepting applications for classes beginning July 2007

Psychopharmacology Training for Practicing Psychologists

This intense curriculum is modeled upon the recommendations of a Blue Ribbon Task Force composed of national experts in psychopharmacology (including physicians, psychiatrists, Department of Defense Demonstration Project prescribing psychologists, neuroscientists, pharmacists and nurses) that developed a framework for training psychologists in psychopharmacology. Students receive extensive education in psychopharmacology, physical assessment, pathophysiology and psychotropic/psychotherapeutic intervention in a format consistent with psychologists' broadly humanistic tradition and biopsychosocial orientation.

The goal is to provide high quality training in psychopharmacology for psychologists to work as primary healthcare providers, supporting patients' emotional and physical well-being. The training builds upon the unique expertise of psychologists as clinicians, diagnosticians, and researchers in mental health.

A unique feature of the SIAP/NMSU training program is extensive theoretical and experiential learning in pathophysiology and physical assessment at a Family Practice Resident Training facility in Las Cruces, New Mexico. This part of the program utilizes the most current approaches to medically-oriented postgraduate education. Organized around evidence-based medicine and organ systems, as taught in many US medical schools, the educational content is presented in a multi- and cross-disciplinary manner.

SIAP is approved by the American Psychological Association to offer continuing education for psychologists. Continuing education credit is available for academic coursework (CEP 801-810). The preceptorship will not receive continuing education credit. SIAP maintains responsibility for the program.

Current Faculty

Don Fineberg, M.D., Board certified in psychiatry and neurology, currently in private practice in Santa Fe, New Mexico.

Douglas Hoffman, Ph.D., Neuropsychopharmacology Specialist, Adjunct Professor, Antioch-New England Graduate School, Department of Applied Psychology.

Marlin Hoover, Ph.D., Conditional Prescribing Psychologist, Behavioral Medicine Faculty, Southern New Mexico Family Practice Residence Program.

Mark Leatherwood, M.D., Southern New Mexico Family Practice Residence Program, Memorial Medical Center in Las Cruces, New Mexico.

Elaine LeVine, Ph.D., Conditional Prescribing Psychologist, Southwestern Institute for the Advancement of Psychotherapy New Mexico State University Collaborative Training Program, Training Director.

Elaine Mantell, Ph.D., ABPP, Prescribing Psychologist from the Department of Defense Demonstration Project.

James Meredith Ph.D., ABPP, Prescribing Psychologist from the Department of Defense Demonstration Project.

Rocsanna Namdar, Pharm.D., Associate Professor of Pharmacy Practice, University of New Mexico, Albuquerque, New Mexico.

John Preston, Psy.D., Board certified clinical neuropsychologist and author of numerous texts on psychopharmacology.

Ricardo Rubio, M.D., Southern New Mexico Family Practice Residence Program, Memorial Medical Center in Las Cruces, New Mexico.

Mitchell Simson, M.D., Internist and Chemical Dependency Specialist, Albuquerque, University of New Mexico, Albuquerque, New Mexico.

Rosario Soriano-Turque, M.D., Southern New Mexico Family Practice Residence Program, Memorial Medical Center in Las Cruces, New Mexico.

Linda Summers, Ph.D., RN, FNP, Program Director of Adolescent Services for New Mexico Adolescent and Young Adult Health Consortium.

Jackie Williams, DSN, CNS, CNP, Assistant Professor of Nursing at New Mexico State University, Las Cruces, New Mexico.

Training in Progress

The first iteration of ten students completed their coursework in 2002, and a second iteration of twenty-two students finished in December of 2004. A third iteration of 18 students will complete their coursework in May of 2007. The SIAP Training Program is increasingly institutionalized at New Mexico State University and trains nationally, including students from New Mexico, Florida, California, Colorado, Kansas and Arizona.

Prerequisites

- *A doctoral degree in psychology*
- *A current state license as a psychologist*
- *Authorization to practice as a health service provider psychologist as defined by state law*

PROGRAM OF STUDY
Didactic Instruction

The program is presented in discrete 3-credit courses organized into content-based sequences of two, three and four courses. Courses are offered every five weeks for two years. Students receive 800-level credit from the Department of Counseling and Educational Psychology at New Mexico State University, which delivers an APA accredited counseling psychology program.

CEP 801 Introduction to physiology and an overview of gross and microanatomy (3)
CEP 802 Principles of organic chemistry and human biochemistry (3)
CEP 803 Introduction to pharmacology: pharmacoepidemiology, ethical, and legal issues; principles of pharmacokinetics and pharmacodynamics (3)
CEP 804 Diagnosis and treatment of affective disorders (3)
CEP 805 Diagnosis and treatment of psychosis (3)
CEP 806 Introduction to human clinical physical assessment, history taking, charting, and laboratory testing and neuroimaging (3)
CEP 807 Physical assessment and pathophysiology (3)
CEP 808 Physical assessment and pathophysiology (3)
CEP 809 Psychopharmacology of special populations (3)
CEP 810 Pathophysiology and treatment of substance use disorders (3)
Preceptorship (6)

Montana State Legislature

Exhibit Number: 6

This exhibit is a booklet Which can not be scanned, the front cover has been scanned to aid in your research the original is on file at the Montana Historical Society and may be viewed there.

Montana Historical Society Archives, 225 N. Roberts, Helena, MT 59620-1201;
phone (406) 444-4774.
Scanning done by: Susie Hamilton

EXHIBIT 6
DATE 2.23.07
SB 522

MSPP

Massachusetts School of Professional Psychology

Master of Science in Clinical Psychopharmacology

2005-2006

Montana State Legislature

Exhibit Number: 6

This exhibit is several deep colored pages in text. Which can not be scanned in its entirety – only the title page has been scanned to aid you in your research. The originals can be viewed at the Montana Historical Society.

Montana Historical Society
Archives
225 N. Roberts
Helena MT 59620-1201
Phone (406) 444-4774
2007 Legislative Scanner Susie Hamilton

PUBLIC HEALTH, WELFARE & SAFETY
Exhibit No. 6
Date 2-23
Bill No SB 522

Senate Bill 522

Prescription privileges for licensed psychologists

Prepared by the Montana Psychological Association on February 22, 2007